

Medical/Family History Questionnaire

Practice Name: _____
 Patient Name: _____
 Address: _____

 Source of Information: _____

Date of Entry: _____
 Date of Birth: _____
 Phone No.: _____
 Emergency No.: _____
 Relationship: _____

Mother's Pregnancy/Child's Birth History: (under 2 yrs old)

Illness during pregnancy? NO YES
 Any medications during pregnancy? NO YES
 Alcohol/Drug Abuse NO YES
 Problems at birth? NO YES
 Describe: _____
 Type of Delivery? Vaginal C-Section
 Birth Weight: _____ Discharge Weight: _____
 Did baby receive Hepatitis B vaccine? NO YES
 Date of Hepatitis B vaccine: _____
 Name of Hospital: _____
 Was first PKU done? NO YES

Patient's Health History: Has your child ever had:

Measles/Mumps/Chicken Pox NO YES
 Frequent ear infections NO YES
 Vision/Hearing Problems NO YES
 Skin Problems NO YES
 Asthma/Allergies NO YES
 TB/Lung Disease/Croup NO YES
 Seizures/Epilepsy NO YES
 High Blood Pressure NO YES
 Heart Defects/Disease NO YES
 Liver Disease/Hepatitis NO YES
 Diabetes NO YES
 Kidney Disease/Bladder Infections NO YES
 Handicaps/Disabilities NO YES
 Bleeding Disorders/Hemophilia NO YES
 Sexually Transmitted Diseases NO YES
 Emotional Problems/Suicide Attempts NO YES
 Hospitalizations/Surgeries NO YES
 Physical/Emotional Abuse/Broken Bones NO YES
 Immunizations Up-To-Date NO YES

Psycho-Social History:

How many living in the household? _____
 Who cares for the child? _____
 Are parents working: NO YES
 Name of school: _____
 Grade: _____
 Behavior problems: _____

Family History: Has anyone in the family (parents, grandparents, aunts & uncles, sisters & brothers, cousins, etc.) had the following: Who:

TB/Lung Disease NO YES _____
 HIV/AIDS NO YES _____
 Suicide Attempts NO YES _____
 Heart Disease NO YES _____
 High Blood Pressure NO YES _____
 High Cholesterol NO YES _____
 Blood Disorders NO YES _____
 Diabetes NO YES _____
 Seizures NO YES _____
 Allergies/Asthma NO YES _____
 Mental Retardation NO YES _____
 Mental Illness NO YES _____
 Cancer NO YES _____
 Birth Defects NO YES _____
 Hearing/Speech Problems NO YES _____
 Kidney Disease NO YES _____
 Alcohol/Drug Abuse NO YES _____
 Stroke NO YES _____
 Hepatitis/Liver Disease NO YES _____
 Thyroid Disease NO YES _____
 Learning Problems NO YES _____
 Attention Deficit Disorder NO YES _____
 Family Violence NO YES _____

Adolescent History: (Interview separately)

Age at first period _____ LMP _____
 Sexually Active NO YES # of partners _____
 Sex of partners MALE FEMALE
 Any fears of partner/other violence? NO YES
 Smoker: NO YES Alcohol Use: NO YES
 Drug Use: NO YES Working: NO YES
 Do you think about hurting yourself? NO YES
 Access to gun/weapon: NO YES

Comments: _____

Updates: _____/_____/_____/_____/_____/_____/_____

Provider Signature: _____ Date: _____